MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05159

Reg. Dist. No. 5166

1. PLACE OF DEATH
a. COUNTY Worcester MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ocean City (RURAL)
c. LENGTH OF STAY IN 1b 30 years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Route 50

2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)
a. STATE Md
b. COUNTY Wor.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x Ocean City (RURAL)
d. STREET ADDRESS Route 50
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First Reece Middle Harley Benston Last
4. DATE OF DEATH Month April Day 26 Year 1958

5. SEX Male
6. COLOR OR RACE White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH July 6 1893
9. AGE (In years last birthday) 64 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter
10b. KIND OF BUSINESS OR INDUSTRY Building
11. BIRTHPLACE (State or foreign country) Md
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME William Benston
14. MOTHER'S MAIDEN NAME Lenora Savage

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WW I
16. SOCIAL SECURITY NO. 219-12-1390
17. INFORMANT Mrs Viola M. Benston Address Ocean City, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Coronary Thrombosis Acute.	Instant
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b)	Coronary Sclerosis	4 years.
DUE TO (c)	Generalized A-S CVD	4 years.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☐, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE F. Townsend Jr. M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
EXAMINER'S NAME (Type) Francis J. Townsend JR
DATE SIGNED April 28, 58.

22a. BURIAL, CREMATION, REMOVAL (Specify) Buried
22b. DATE THEREOF 4/29/58
22c. NAME OF CEMETERY OR CREMATORY Dodd
22d. LOCATION (City, town, or county) (State) Bishopville Md.

23. FUNERAL DIRECTOR'S SIGNATURE Peter Whaley ADDRESS Bishopville, Md.
24a. REC'D BY REGISTRAR DATE APR 30 '58
24b. REGISTRAR'S SIGNATURE Reed Smith

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A1SME(S)
5M 9/55

1

M

05160

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

5167

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY: Worcester, MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Md. b. COUNTY: Worcester
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Pocomoke; c. LENGTH OF STAY IN 1b: All Life	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural - Pocomoke City Md
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Rur.	d. STREET ADDRESS: R.D. 2; e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First: Charley; Middle: Irving; Last: Coston	4. DATE OF DEATH Month: April; Day: 3rd; Year: 1958

5. SEX	6. COLOR OR RACE	7. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months / Days	IF UNDER 24 HRS. Hours / Min.
M	C	MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	April ? 1883	74 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Preacher & Laborer	Ministry & Farm	Pocomoke City RR2	U. S. A

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Ephriam Coston	Mary Tinn

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT / Address
No		Isaah Coston - Pocomoke City Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary occlusion — minutes

420.1

DUE TO (b) Arteriosclerosis

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): The deceased while driving his station-wagon, left the road and struck a telephone pole. - No bodily damage to him.

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☒ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) No injury apparent

20c. TIME OF INJURY Hour a.m. p.m. / Month, Day, Year	20d. INJURY OCCURRED	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
4 p.m. / 4 3 1958	While at work ☐ Not while at work ☒	Highway 113	Rural Pocomoke, Worcester, Md

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: N. F. Sartorius Jr. M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED: 4/4/58

EXAMINER'S NAME (Type): N. F. Sartorius Jr. MD

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial	4-6-58	Johnson Neck	Pocomoke Md.

23. FUNERAL DIRECTOR'S SIGNATURE / ADDRESS	24a. REC'D BY REGISTRAR	24b. REGISTRAR'S SIGNATURE
Edgar W. Easton, New Church, Va	DATE APR 7 '58	[illegible]

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5168

CERTIFICATE OF DEATH

05161

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be removed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1. PLACE OF DEATH
a. COUNTY: Worcester — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Snow Hill
c. LENGTH OF STAY IN 1b: 10 yrs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Md
b. COUNTY: Worcester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): × Snow Hill Rural #2
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print): First: Irene — Middle: H. — Last: Denney

4. DATE OF DEATH: Month: April — Day: 22 — Year: 1958

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: July 10 1913

9. AGE (In years last birthday): 44 9/12 yrs.

IF UNDER 1 YEAR — Months: — Days: — IF UNDER 24 HRS. — Hours: — Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: own home

11. BIRTHPLACE (State or foreign country): Cleveland Ohio

12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: Victor Wenrich

14. MOTHER'S MAIDEN NAME: Emily Taffan

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: 214-32-0287

17. INFORMANT: Mrs Filay R. Denney — Address: Snow Hill Md Rural #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): CACHEXIA & INANITION — INTERVAL BETWEEN ONSET AND DEATH: 2 mos

151X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): GASTRIC ADENOCARCINOMA — 1 YR

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY — Month, Day, Year — Hour o. m. p. m. — 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from SEPT 1, 1957, to APRIL 22, 1958, that I last saw the deceased alive on APRIL 20, 1958, and that death occurred at 9:45 P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Robert C. LaMar M.D. — ADDRESS (Street, city or town, state): 104 Bay Street — DATE SIGNED: 4-23-58

PHYSICIAN'S NAME (Type): Robert C. LaMar, M.D. — Snow Hill, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: April 25 '58

22c. NAME OF CEMETERY OR CREMATORY: Presbyterian Cemetery

22d. LOCATION (City, town, or county) (State): Snow Hill, Md

23. FUNERAL DIRECTOR'S SIGNATURE: Clay E. Timmons — ADDRESS: Snow Hill Md

24a. REC'D BY REGISTRAR — DATE: APR 24 '58

24b. REGISTRAR'S SIGNATURE: [signature]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

5163

Reg. Dist. No. 05162

1. PLACE OF DEATH
a. COUNTY: Worcester — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Pocomoke City
c. LENGTH OF STAY IN 1b: Life
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 800 Walnut Street

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Worcester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 42 Pocomoke City
d. STREET ADDRESS: 800 Walnut Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: WILLIAM — Middle: F. — Last: ENNIS

4. DATE OF DEATH: Month: April — Day: 2, — Year: 1958

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: April 11, 1897

9. AGE (In years last birthday): 60 yrs.

IF UNDER 1 YEAR / IF UNDER 24 HRS. — Months / Days / Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer

10b. KIND OF BUSINESS OR INDUSTRY: Farming

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Sidney C. Ennis

14. MOTHER'S MAIDEN NAME: Rose Matthews

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): WW #1

16. SOCIAL SECURITY NO.:

17. INFORMANT — Address: Mrs Nettie F. Ennis, Pocomoke City, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: 2 hours

420.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Coronary Artery Disease — 4 years.

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Cancer of the Bladder —

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: White at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from April 2, 1958, to April 2, 1958, that I last saw the deceased alive on April 2, 1958, and that death occurred at 12:30 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Charles W. Trader M.D. — ADDRESS (Street, city or town, state): 302 Market St — DATE SIGNED: Apr. 3, 1958

PHYSICIAN'S NAME (Type): Charles W. Trader — Pocomoke City, Md

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 4-5-58

22c. NAME OF CEMETERY OR CREMATORY: Salem Methodist

22d. LOCATION (City, town, or county) (State): Pocomoke City, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Henry A. Watson — ADDRESS: Pocomoke City, Md

24a. REC'D BY REGISTRAR — DATE: APR 7 '58

24b. REGISTRAR'S SIGNATURE: W. Leach

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled [illegible] the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

#1

Items 18-21 Film 227 4-15-58 ams

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05163

5169

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Worcester — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Ocean City (Rural)
c. LENGTH OF STAY IN 1b: —
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Beach - 3 miles South

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Pennsylvania
b. COUNTY: ✓
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Upper Darby — 75 X-3
d. STREET ADDRESS: 204 Huntley Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Thomas — Middle: E — Last: Gavaghan

4. DATE OF DEATH: Month: April — Day: 7 — Year: 1958

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: June 15, 1919

9. AGE (In years last birthday): 38 yrs.

IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Dredge Worker

10b. KIND OF BUSINESS OR INDUSTRY: Dredging

11. BIRTHPLACE (State or foreign country): Penna.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Michael Gavaghan

14. MOTHER'S MAIDEN NAME: Bridget McCarry

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) Yes (If yes, give war or dates of service) World War 2

16. SOCIAL SECURITY NO.:

17. INFORMANT: Margaret Gavaghan Address: 204 Huntley Rd Upper Darby, Pa.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Deferred pending Autopsy Report

INTERVAL BETWEEN ONSET AND DEATH:

929.9

DUE TO (b): Drowning

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Fell while boarding barge

20c. TIME OF INJURY: Hour: 10:30 a. m. p. m. — Month, Day, Year: 3/27 19 58

20d. INJURY OCCURRED: While at work ☒ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Barge

20f. (City or town) (County) (State): nr. Pennsville New Jersey

21. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☐, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Francis J. Townsend Jr. M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

EXAMINER'S NAME (Type): FRANCIS J. TOWNSEND JR.

DATE SIGNED: April 9, 1958

22a. BURIAL, CREMATION, REMOVAL (Specify):

22b. DATE THEREOF: 4/17/58

22c. NAME OF CEMETERY OR CREMATORY: Cemetery

22d. LOCATION (City, town, or county) (State): Milford, Co. Donegal, Ireland

23. FUNERAL DIRECTOR'S SIGNATURE: Anna A. Burbridge

ADDRESS: Berlin, Md.

24a. REC'D BY REGISTRAR DATE: APR 10 '58

24b. REGISTRAR'S SIGNATURE: [illegible]

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05164
Reg. Dist. No.

5170

1. PLACE OF DEATH
a. COUNTY: Worcester — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural - Berlin
c. LENGTH OF STAY IN 1b: 15 years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address):

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Md. — b. COUNTY: Worcester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): x Berlin
d. STREET ADDRESS: Route 3
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First: Allen — Middle: — Last: Hatten
4. DATE OF DEATH: Month: 4 — Day: 2 — Year: 19-58

5. SEX: Male
6. COLOR OR RACE: C
7. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: May 10 - 1905
9. AGE (In years last birthday): 53 yrs.
IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10b. KIND OF BUSINESS OR INDUSTRY: Lumber Mill
11. BIRTHPLACE (State or foreign country): Georgia
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 259-01-1428
17. INFORMANT: Mrs. Elizabeth Hatten — Address: Berlin, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Broken neck + Multiple Comp'd fractures of
DUE TO: at shoulder and all extremities
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Auto - accident
DUE TO
(c):
INTERVAL BETWEEN ONSET AND DEATH: Very Brief

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of item 18.): Struck by fast traveling Auto while Crossing Highway on foot
20c. TIME OF INJURY: Hour: 7.40 a. m. p. m. — Month, Day, Year: 4 2 1958
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Highway Route 2 — 20f. (City or town): Near Berlin — (County): Worcester — (State): Md

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: N. E. Sartorius M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
EXAMINER'S NAME (Type): N. E. Sartorius
DEPUTY MEDICAL EXAMINER ☑
DATE SIGNED: 3/3/58

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 4-5-58
22c. NAME OF CEMETERY OR CREMATORY: Evergreen
22d. LOCATION (City, town, or county) (State): Berlin Md

23. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: Stewart Funeral Home, Berlin, Maryland
24a. REC'D BY REGISTRAR DATE: APR 8 '58
24b. REGISTRAR'S SIGNATURE: [illegible]

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your [illegible]
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(S)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Items 1, 9 Filed 228 5-12-59 et

Reg. Dist. No. 06304

5171

1. PLACE OF DEATH
a. COUNTY Worcester MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ocean City
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Worcester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ocean City
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First Clarence Middle A. Last Hopkins
4. DATE OF DEATH Month April Day 21 Year 1958
5. SEX Male
6. COLOR OR RACE C.
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ ? DIVORCED ☐
8. DATE OF BIRTH Approx.
9. AGE (In years last birthday) 60 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ?
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) ?
12. CITIZEN OF WHAT COUNTRY? ?
13. FATHER'S NAME ?
14. MOTHER'S MAIDEN NAME ?
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) ? (If yes, give war or dates of service) ?
16. SOCIAL SECURITY NO. 219-18-4736
17. INFORMANT Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lobar Pneumonia, RS Lower Lobe — INTERVAL BETWEEN ONSET AND DEATH 7
490 X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b) Body found appx. 10-14 days after death
DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Generalized Arteriosclerosis
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE Herman A. Robbins M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
EXAMINER'S NAME (Type) HERMAN A. ROBBINS M.D. DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED 5/2/58

22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL
22b. DATE THEREOF 5/3/58
22c. NAME OF CEMETERY OR CREMATORY HUSTON
22d. LOCATION (City, town, or county) Salisbury (State) Md.

23. FUNERAL DIRECTOR'S SIGNATURE Christ. F. Stewart ADDRESS Salisbury Md.
24a. REC'D BY REGISTRAR DATE MAY 7 '59
24b. REGISTRAR'S SIGNATURE

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your [illegible]
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation or removal.

VS. A15ME(S)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5172 CERTIFICATE OF DEATH

Reg. Dist. No. 05165

1. PLACE OF DEATH
a. COUNTY: Worcester — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Berlin
c. LENGTH OF STAY IN 16: 35 yrs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived If institution, Residence before admission)
a. STATE: Md — b. COUNTY: Worcester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Ocean City
d. STREET ADDRESS: 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Eugene — Middle: Rayner — Last: Parker

4. DATE OF DEATH: Month: 4 — Day: 19 — Year: 1958

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒

8. DATE OF BIRTH: Feb 27 1920

9. AGE (In years last birthday): 38 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Bartender

10b. KIND OF BUSINESS OR INDUSTRY: Liquor

11. BIRTHPLACE (State or foreign country): Willards Md

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Mitchell H Parker

14. MOTHER'S MAIDEN NAME: Flora Marie Rayne

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
If yes, give war or dates of service:

16. SOCIAL SECURITY NO:

17. INFORMANT: Mitchell Parker — Address: Ocean City Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Suicide - Carbon Monoxide gas
DUE TO (b): Poison Gas - from exhaust to make fear
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):
INTERVAL BETWEEN ONSET AND DEATH: Minutes

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Sometime out of Employment - Gather a Suicide

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Poison gas - Passed from exhaust pipe by hose to inside of car

20c. TIME OF INJURY Hour a. m. p. m. — Month, Day, Year: 4/19 19 58

20d. INJURY OCCURRED While at work ☐ Not while at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.):

20f. (City or town) Berlin (County) Worcester (State) Md

21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on April 19, 1958, and that death occurred at 7:30 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: N. E. Sartorius M.D. — ADDRESS (Street, city or town, state): Pocomoke City, Md. — DATE SIGNED

PHYSICIAN'S NAME (Type): N. E. Sartorius

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 22b. DATE THEREOF: April 22-58 — 22c. NAME OF CEMETERY OR CREMATORY: Willards — 22d. LOCATION (City, town, or county) (State): Willards Md

23. FUNERAL DIRECTOR'S SIGNATURE: EURBAGE FUNERAL HOME — ADDRESS: Berlin, Md

24a. REC'D BY REGISTRAR DATE: APR 22 '58 — 24b. REGISTRAR'S SIGNATURE:

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be removed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director should be detached far use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5164 CERTIFICATE OF DEATH

Reg. Dist. No. 05166

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH — a. COUNTY: Worcester — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Pocomoke City
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 212 Market Street

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) — a. STATE: Maryland — b. COUNTY: Worcester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Rural Pocomoke City
d. STREET ADDRESS: Twin Towers Motel
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Mary — Middle: Ada — Last: Prosser
4. DATE OF DEATH: Month: April — Day: 12 — Year: 1958

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: January 31, 1902
9. AGE (In years last birthday): 56 yrs.
IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS: Hours: — Min: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Waitress
10b. KIND OF BUSINESS OR INDUSTRY: Restaurant
11. BIRTHPLACE (State or foreign country): Hungary
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Joseph Torok
14. MOTHER'S MAIDEN NAME:

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): — (If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.: 078-16-8359
17. INFORMANT — Address: Mrs Julia Torok, East Pitt Bur., Penna.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): ACUTE MYOCARDIAL INFARCTION — INTERVAL BETWEEN ONSET AND DEATH: 2 HOURS
420.1
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year, Hour a. m. p. m., 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from APR. 12, 1958 to APR. 12, 1958 that I last saw the deceased alive on APR. 12, 1958, and that death occurred at 1 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: C. Stanford Hamilton M.D. — ADDRESS (Street, city or town, state): 212 MARKET ST. — DATE SIGNED: 4/14/58
PHYSICIAN'S NAME (Type): C. STANFORD HAMILTON — POCOMOKE CITY, MD.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 4-17-58
22c. NAME OF CEMETERY OR CREMATORY: St. Peter Methodist
22d. LOCATION (City, town, or county) (State): Pocomoke, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Henry H. Watson — ADDRESS: Pocomoke City, Md.
24a. REC'D BY REGISTRAR DATE: APR 18 '58
24b. REGISTRAR'S SIGNATURE: A. W. Leach

VE A15 (4) 15M 8/58

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05167

5173 CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

M

00

1

1. PLACE OF DEATH
a. COUNTY: WORCESTER — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): NEWARK-RURAL
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: WORCESTER
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): x RURAL - NEWARK
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print): First: John — Middle: William — Last: PURNELL

4. DATE OF DEATH: Month: APRIL — Day: 30 — Year: 1958

5. SEX: MALE

6. COLOR OR RACE: C

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐

8. DATE OF BIRTH: Feb. 28, 1876

9. AGE (In years last birthday): 82 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): LABORER ON FARM

10b. KIND OF BUSINESS OR INDUSTRY: FARM LABOR

11. BIRTHPLACE (State or foreign country): NEWARK, MARYLAND

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: WILLIAM PURNELL

14. MOTHER'S MAIDEN NAME: MARY JANE PURNELL

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: No

17. INFORMANT — Address: CHARLOTTE PURNELL NEWARK, md.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Heart Block — INTERVAL BETWEEN ONSET AND DEATH: 4 wks
433.0
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b): Chr. Myocarditis
DUE TO
(c): Arteriosclerosis

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour a.m. p.m., 19

20d INJURY OCCURRED While at work ☐ Not while at work ☐

20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that I attended the deceased from April, 1958, to May 30, 1958, that I last saw the deceased alive on 29 April, 1958, and that death occurred at 8 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: Chas. R. Law M.D. — ADDRESS (Street, city or town, state): Berlin Md — DATE SIGNED: 5-1-1958

PHYSICIAN'S NAME (Type):

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: MAY 3, 1958

22c. NAME OF CEMETERY OR CREMATORY: CEDAR CHAPEL

22d. LOCATION (City, town, or county) (State): NEWARK MARYLAND

23. FUNERAL DIRECTOR'S SIGNATURE: Anna M. Burbage — ADDRESS: Berlin Md

24a. REC'D BY REGISTRAR DATE: MAY 5 '58

24b. REGISTRAR'S SIGNATURE: Whitesell

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5174 CERTIFICATE OF DEATH

Reg. Dist. No. 05168

1. PLACE OF DEATH
a. COUNTY: Worcester — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Snow Hill
c. LENGTH OF STAY IN 1b: All her life
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2 USUAL RESIDENCE (Where deceased lived If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Worcester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Snow Hill
d. STREET ADDRESS: 210 Collins Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Mary — Middle: Emma — Last: Robbins

4. DATE OF DEATH: Month: 4 — Day: 13 — Year: 19 58

5. SEX: FM

6. COLOR OR RACE: AA

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8 DATE OF BIRTH: 1 28 1884

9. AGE (In years last birthday): 74 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife

10b. KIND OF BUSINESS OR INDUSTRY: None

11 BIRTHPLACE (State or foreign country): Maryland

12 CITIZEN OF WHAT COUNTRY?: USA

13 FATHER'S NAME: John Spence Parker

14. MOTHER'S MAIDEN NAME: Emma Dale

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: None

17. INFORMANT — Address: Mrs. Emma K. Day, 2536 Madison Ave, Balti, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 1 day
420.1
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Diabetes Mellitus

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour: a. m. / p. m. — Month, Day, Year: 19

20d INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 4/13/58, 19____ to 4/13/58, 19____, that I last saw the deceased alive on 4/13/58, 19____, and that death occurred at 4:30 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Paul Cohen M.D. — ADDRESS (Street, city or town, state): Snow Hill Md — DATE SIGNED: 4/16/58

PHYSICIAN'S NAME (Type): Paul Cohen, M.D. — 104 S. Church St., Snow Hill, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 4-17-58
22c. NAME OF CEMETERY OR CREMATORY: Ebneezer Cemetery
22d LOCATION (City, town, or county) (State): Snow Hill, Md

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: J. F. Stewart Funeral Home, Salisbury, Md

24a. REC'D BY REGISTRAR — DATE: APR 21 '58

24b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5175 CERTIFICATE OF DEATH

Reg. Dist. No. 05170

1. PLACE OF DEATH
a. COUNTY: Worcester — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Snow Hill
c. LENGTH OF STAY IN 1b: 63 yrs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Md — b. COUNTY: Worcester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): x Snow Hill
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First Sadie — Middle E. — Last Shackley

4. DATE OF DEATH: Month April — Day 1 — Year 1958

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: June 2 - 1882
9. AGE (In years last birthday): 76/9/29
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Salisbury, Md
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: John T. Gordy
14. MOTHER'S MAIDEN NAME: Mary Layfield

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Mrs. Paul Shackley — Address: Snow Hill Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): ACUTE CORONARY OCCLUSION — INTERVAL BETWEEN ONSET AND DEATH: NONE
420.1
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) ATHEROSCLEROSIS — 10 YRS
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Month, Day, Year — Hour a. m. p. m. — 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from APRIL, 1955 to APRIL 1, 1958 that I last saw the deceased alive on MARCH 30, 1958, and that death occurred at 5:30 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Robert C. LaMar M.D. — ADDRESS (Street, city or town, state): 104 Bay St., Snow Hill, Md. — DATE SIGNED: 4/2/58

PHYSICIAN'S NAME (Type): Robert C. LaMar, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 22b. DATE THEREOF: April 4 58 — 22c. NAME OF CEMETERY OR CREMATORY: Bates Methodist — 22d. LOCATION (City, town, or county) (State): Snow Hill Md

23. FUNERAL DIRECTOR'S SIGNATURE: Elwood E. Timms — ADDRESS: Snow Hill Md

24a. REC'D BY REGISTRAR — DATE: APR 3 '58 — 24b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5165

CERTIFICATE OF DEATH

Reg. Dist. No. 05169

1. PLACE OF DEATH
a. COUNTY: Worcester — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Pocomoke City
c. LENGTH OF STAY IN 1b: 35 years
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 601 Fourth Street

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Worcester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 42 Pocomoke City
d. STREET ADDRESS: 601 Fourth Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First LOUISE Middle A. Last SHAW

4. DATE OF DEATH: Month April Day 7 Year 1958

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: July 18, 1870

9. AGE (In years last birthday): 87 yrs.
IF UNDER 1 YEAR: Months ____ Days ____
IF UNDER 24 HRS.: Hours ____ Min. ____

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife

10b. KIND OF BUSINESS OR INDUSTRY: ----

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Stansbury Hearn

14. MOTHER'S MAIDEN NAME: Lavania Hastings

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): ---

16. SOCIAL SECURITY NO.: None

17. INFORMANT Address: Mrs Paul Vincent, Pocomoke City, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): MYOCARDIAL INSUFFICIENCY — INTERVAL BETWEEN ONSET AND DEATH: 2 YRS.

420.1

DUE TO (b): ATHROSCLEROTIC CORONARY ARTERY DISEASE — 30 YRS.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c): GENERALIZED ATHROSCLEROTIC VASCULAR DISEASE — 30 YRS

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from DEC. 1, 19 57, to APRIL 7, 19 58, that I last saw the deceased alive on APRIL 7, 19 58, and that death occurred at 2 30 P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: C. Stanford Hamilton M.D. ADDRESS (Street, city or town, state): 212 MARKET ST. DATE SIGNED: 4/5/58

PHYSICIAN'S NAME (Type): C. STANFORD HAMILTON POCOMOKE CITY, MD.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 4-10-58

22c. NAME OF CEMETERY OR CREMATORY: Pitts Creek Presbyterian

22d. LOCATION (City, town, or county) (State): Pocomoke City, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Henry H. Watson ADDRESS: Pocomoke, Md.

24a. REC'D BY REGISTRAR DATE: APR 11 '58

24b. REGISTRAR'S SIGNATURE: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55